IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

- - - - -

Joseph Hines, :

Plaintiff, :

vs. : Case No. 2:13-cv-1058

City of Columbus, et al., :

Defendants. :

- - - - -

DEPOSITION OF GERALD A. SHIENER, M.D.

- - - - -

Taken at 251 Merrill Street, Suite 230
Birmingham, Michigan
Commencing at 5:20 p.m.
Tuesday, February 10, 2015,

- - - - -

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EXHIBITS

(Original exhibit returned to Mr. Phillips.)

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MARKED BY THE REPORTER:

DEPOSITION EXHIBIT 1

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GERALD SHIENER, M.D.,

was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

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EXAMINATION

BY MR. MANGAN:

Q. Could you please state your full name and your address?

A. Gerald Alan Shiener, 251 East Merrill Street, Suite 230, Birmingham, Michigan 48009.

Q. Good afternoon, Doctor. My name is Tim Mangan. I'm the Assistant City Attorney for the City of Columbus. I'm here with Wes Phillips today, and we are going to ask you questions about an evaluation and report that you did in this case. Do you understand that?

A. Good afternoon. Yes, and I do have that understanding.

Q. Okay. What I'm going to do is I know you have been deposed before, so I'm not going to go through it all. If you don't understand my question, just let me know. I will rephrase it.

A. I will do my best.

Q. If you answer my question, I am going to presume you understand it, okay?

A. I will do my best to make sure I don't answer anything I don't understand.

Q. Okay. I'm going to hand you what I have marked as Exhibit 1.

A. Yes.

Q. Are you familiar with that?

A. I am.

Q. Is that the report that you completed on November 18th, 2014?

A. It's a copy of that report, yes.

Q. Okay. It was based on your examination of Joseph Hines on November 17th, 2014; is that true?

A. That's correct.

Q. Now, Doctor, I'm going to ask you a bunch of questions about the report, but you saw Joseph Hines on November 17th, 2014, correct?

A. I did.
Q. Is that the only time you have ever seen him?
A. It is.
Q. You have not seen him before or since?
A. Not before and not since.
Q. I know that we are going to go through what you reviewed and what you based your opinions on. Have you reviewed or talked to or done anything else with respect to Joseph Hines other than what you have included in your report?
A. No, I haven't.
Q. Doctor, I just want to clarify one thing. Were you contacted by Joseph Hines' attorneys in order to do an evaluation and report?
A. I was.
Q. Okay. And you understand that it was, in part, with respect to litigation that was occurring that Joseph Hines had brought?
A. I understood that there was some possibility that litigation would be involved.
Q. Okay.
A. I didn't know the status of the litigation.

Q. Who contacted you?
A. Probably Miss Glazer's secretary or maybe Mr. Harrington's secretary.
Q. Joseph Hines didn't contact you to set up the appointment or anything, did he?
A. No, he didn't.
Q. I just wanted to -- the first paragraph of your report, I just want to clarify. It says there that "he," meaning Joseph Hines, "consulted me for difficulties he had been experiencing after he was assaulted on August 29th, 2012." Do you see that?
A. I do.
Q. Isn't it true though that you were actually doing this as an evaluation and report for the possibility of litigation?
A. Well, we have already established that, but the reason he consulted me was for that difficulty of living.
Q. Okay. But you don't --
A. He didn't come in and say my attorney just told me to come here. He told me he had been struggling since the police beating.
Q. But the attorney was the one that

contacted you?
A. I have already said that.
Q. You don't include that in your report, do you?
A. Who called to make the appointment? I wouldn't typically do that.
Q. There is nothing in the report that reflects that you were consulted by the attorney in order to do an evaluation and report possibly related to a litigation; is that correct?
A. Well, I mean it is addressed to the attorney. I'm not sure what else I could do.
Q. But is there any reason why you didn't put that in the body of your report, what you were consulted about?
A. I told you. I was consulted because this young man had been struggling since he was assaulted on August 29th, 2012.
Q. Now, when you say assaulted, are you using it as a legal term?
A. No. I'm using it as a layman would. I'm not a lawyer.
Q. The only thing you knew about the incident is what Joseph Hines told you about?

A. Well, let me just answer it this way and see if this clears up your understanding. I took a history. The history came from the patient. That is the history he provided me. I did have some collateral documents, numbers one through five, and then I had a conversation with his mother and father, collateral history, but they weren't there during this incident, so I didn't really take a history of the incident from them.

Q. It's fair to say, Doctor, you did not do an independent investigation of the incident that is at issue, did you?

A. That would really be beyond the scope of what I was asked to do. I didn't conduct my own police type investigation of what happened. I just took a history from the patient and made a diagnosis and reviewed some collateral medical information and took some background collateral history from his mom and dad.

Q. So when you use the term "assault," you are not sure what happened that day other than what Joseph Hines told you?

A. Well, that is history. History comes

from the patient. When I use the term "assault," I'm not using it as a judge might or a police officer might or as an attorney might.

Q. Isn't it true when he told you that he doesn't remember much of the incident, the actual incident that occurred, does he?

A. He told me he had some impaired recollection, but I think that there is some reasonable inferences that can be made from the description of his condition at the time he was admitted to the hospital.

Q. Okay. But you don't know what he did or what the police officers did?

A. No, I didn't see what happened.

Q. Right.

A. I will defer that to the finder of fact in this matter.

Q. And just to go through your report, you spoke to Joseph Hines and obtained a history from him, which is pretty much pages 1, 2 and 3 of your report, correct?

A. With the exception that there are some parts of those pages where I think I speak to what the mom told me and what the dad told me.

Q. I think you do later in your report, Doctor.
A. That could be. That may be under review of documentation.
Q. I'm just trying to get the format.
A. Sure.
Q. Then you also indicate that you reviewed records from Allegiance Health, an MRI on the first page?
A. Yes.
Q. Grant Medical Center records, University of Michigan records, Dr. Corey --
A. Yes.
Q. -- University of Michigan neuropsych records and the Ohio State University records as it relates to therapy; is that correct?
A. That's right.
Q. You didn't review any other documents other than those listed there?
A. If I had, I would have listed them.
Q. Okay. As we sit here today, and based on your review of those records, you don't challenge the qualifications or expertise of those caregivers or persons in those reports to render

the conclusions that they did?

A. I can't think of any issue -- as we sit here at this point, I can't think of any issue I take with them. I mean, you know, I may discuss some of their findings critically. I may, you know, if they talk about neuropsychological assessment, I may have some other conclusions or some issues with some of the numbers, but nothing sticks out in my mind.

Q. Isn't it fair to say though that in the report that you do render you do not challenge the qualifications or the expertise or the ability of those caregivers to render the conclusions or draw the conclusions?

A. None of that language appears in my report.

Q. And then, Doctor, when we go to -- after you go through the history, which was taken from Joseph Hines as you said, then you have some personal history, prior employment history, past medical history, which was taken from him and probably from the parents and perhaps from the medical records, correct?

A. Well, no. In this section this history

comes from the patient. If there is anything that the parents endorsed or that the parents described, I would specify the source of the parents, and then what came from the documentation is under the section review of documentation.

Q. Okay. And then the next part is where you describe your mental status examination; is that correct?

A. That's right.

Q. After that you do render your diagnostic impression?

A. That's right.

Q. And that is based on the Diagnostic Statistical Manual, correct?

A. It follows the format suggested in that document.

Q. I'm just trying to, at the end, the last page -- well, page 7 and finishing on page 8 you term it as "discussion."

A. That's right.

Q. Are these the opinions that you have rendered in this case?

A. Well, that is what we call a formulation, and they are a representation of my

opinions. I can talk about this matter at greater length, and I assume that is why you came here, than to just rely on these four paragraphs.

Q. Right. What I'm saying is, just to make sure, in addition to your diagnostic impression, the discussion encompasses all the opinions you have rendered in this case?

A. Well, when you stay all of the opinions, if they were all of the opinions, I'm not sure why you would be coming up here to talk to me about it. There may be other opinions I may have, or I may be able to elaborate on these opinions. I tried to give a representation of what I heard, what I saw, integrating it with what I read and then combining that with what I know about these conditions and these kind of cases, a diagnostic impression and what I thought had happened to him and what I thought his needs were.

Q. Okay. I just want to make sure that there aren't other opinions out there that you have rendered in addition to those included in your report at pages 7 and 8.

A. I tried to be thorough in my report, but if you ask me to discuss these matters, I can

certainly elaborate. I can't tell you what Mr. Fieger or Miss Glazer or Mr. Harrington might ask me at trial.

Q. I'm not asking that. I'm just trying to clarify.

A. I --

Q. Let me finish my question. All I'm trying to do clarify is you are not aware of any other opinions that you have in regard to this case other than those included in your report?

A. Well, I don't know if I can say that because you are coming here to discuss these things. You are going to ask me questions. I mean if you want, I can -- whenever you ask me a question, I can refer you to these four paragraphs, but that is not why you are here. You are here for me to discuss these things. I may elaborate or describe them in some more detail, or something that I say may flow out of these opinions, but it may not be stated.

Since you are such a stickler for why I didn't say Miss Glazer's secretary called and made the appointment instead of that this man consulted me, I want to be very careful in how I answer

these questions.

Q. Well, Doctor, that's not really what I asked you. I'm just trying to find out --

A. Well, no.

Q. I am not trying to make it difficult. I am just trying to find out -- I need to know when I leave here today have you rendered any other opinions as it relates to Joseph Hines for purposes of this litigation other than what you have included in your report. That is all I'm asking.

A. I can't say that then for the reasons I have said about three times. But maybe it would best serve you, and I'm not really here to advise you, maybe it would best serve you to ask all the questions that you have and then ask that as your last question.

Q. Okay. You can't say whether or not you have any additional opinions other than what is included in your report?

A. Because I don't know what you are going to ask me.

Q. Okay. Now, Doctor, I want to clarify. You indicated in your diagnostic impression that

it's your conclusion that Joseph Hines has posttraumatic stress disorder; is that correct?

A. That's right.

Q. You have a cognitive and mood disorder secondary to traumatic brain injury, frontal lobe type, correct?

A. That's right.

Q. Is are those your diagnoses as to him?

A. Yes.

Q. Okay. I want to then start with that. You talk about -- we are going to talk about PTSD. We are going to talk about the cognitive function as well. I just want to ask you about the secondary to traumatic brain injury. Upon what do you base your opinion that he has suffered brain injury?

A. Well, the history that I have. This is a young man that was functioning without difficulty, seemed to do well in high school, was able to function in college, had an encounter that he described with a group of police officers, and he described being taken to the ground. He described regaining consciousness with handcuffs and with his eyes swollen shut.

So I had a history of some head trauma, facial trauma, and I think that that is consistent with the records that I reviewed. He had stitches to his right temple and around his orbit. He was described in the records as demonstrating -- manifesting a peribulbar hemorrhage on the left eye. There was a history of a loss of consciousness.

Q. What do you base the history of loss of consciousness from?

A. That was from the Grant Medical Center.

Q. Do you have any knowledge of whether or not he did or did not lose consciousness?

A. I wasn't there, and I didn't see it. I have that history. I have a history -- let me finish. I have history of an impaired recollection where he said, "That was the last thing I remember, and then I woke up with all these bruises around my face."

I have objective evidence of bruising because that is quite specifically described. Then I have a history of loss of consciousness. So that is all consistent. But was I an eyewitness to that? No.

Q. And --
A. Do you want me to finish answering your other question, or are we moving on?
Q. Sure. Go ahead.
A. So I have all that history and all those description of findings. Then I have a history of poor memory, poor concentration, dismal school performance and a deterioration from his prior performance, a change in his demeanor with irritability that is out of character for him, and then I have a neuropsychological assessment from the University of Michigan that describes areas of impaired function.
Q. Let me ask you about the physical injury. Are you aware of any test or any physical indication of injury? You said that you have received reports from Joseph Hines. You have looked at the medical records, which are part of everything. Did you see any testing or any physical indication that he had suffered brain injury as you term it?
A. So your question is did I see any physical evidence that he suffered brain injury?
Q. Yes.

A. That is your question, because I want to get to the question, not the preamble and not the other part that you said. Just so I'm sure I understand your question, so your question is did I see any physical evidence.

What I would say is the description from the hospital of peribulbar bruising, impact that would break -- impact to the face that would break the skin, the peribulbar hemorrhage, that would be presumptive evidence of brain damage, and that impact capable of causing that kind of soft tissue damage would cause damage to the underlying brain tissue.

Q. Okay. In addition to the presumptive evidence of brain damage, are there any other tests or physical tests that were done that you have reviewed in the record that would indicate brain injury upon which you base your opinion on?

A. Your question is besides what I just said are there any other tests. When you use the term "physical tests," I'm not sure I understand what you mean.

Q. Any tests that you could see or observe something that would indicate that.

A. What is a physical test?

MS. GLAZER: Are you asking him for objective evidence?

MR. MANGAN: I will ask.

BY MR. MANGAN:

Q. Well, I want you to tell me everything upon which you base your conclusion there was brain injury, and you have already done some, and that is on the record.

A. I tried to be thorough in my report. So let me just say what I saw, what I heard, what I read --

Q. Okay.

A. -- and what I know about how brain damage occurs.

Q. Okay. Now, you know an MRI was done in October of 2012?

A. I do.

Q. What did that show?

A. Let's see.

Q. In your report you did list it here. You can look at your report.

A. Thank you for that. Yes. The MRI was read within normal limits.

Q. Okay. Then in your report you do indicate that the MRI done October 27th, 2012 you indicate in the second -- well, the first full paragraph, "The MRI of the brain" -- let me read it again. "MRI of the brain for reasons of trauma and memory lapse shows no acute intracranial abnormality," correct?

A. That is what it says, yes.

Q. So the MRI was not indicative of a brain injury?

A. No, that is not true. The MRI is a very sophisticated, high resolution picture of the brain that is expressed in pixels or little dots of black and white. The MRI is used to show space-occupying lesions, blood clots, bleeding and brain tumors that would be visible to the naked eye. It's expressed in pixels as I said before. Each pixel would represent about 2,500 brain cells. The effective brain damage in acceleration/deceleration injuries such as sustained by Joseph Samuel Hines would not be apparent on an MRI.

Furthermore, the MRI specifies there is only no acute problems. So this would be

something that might have been more prudently undertaken in the first 24 to 36 hours after this incident rather than weeks later.

Q. But it did show no acute intracranial abnormality, correct?

A. I already answered that.

Q. Isn't that correct?

A. I want to be careful in answering that because I don't want to give an answer that is misleading that leads itself to be distorted because although I agreed to that every time you asked me about what it said, then you said well, it shows no signs of brain damage. That was incorrect. I want to be careful in saying that -- what it says is what it says. There were no acute signs of trauma. The extent that the MRI could visualize anything that would be visible to the naked eye.

Q. And there was no MRI done previously or since then?

A. To my knowledge.

Q. That you are aware of?

A. To my knowledge.

Q. Okay. And then a CT scan was done on

August 30th, 2012. You are familiar with that, aren't you?

A. I am.

Q. What did that show?

A. I'm sorry. I will have to review that document. All right. "CT demonstration indicated extensive facial swelling, left-sided contusions, no subcutaneous gas, soft tissue induration and a retrobulbar lesion on the left with no focal mass. The conclusion was extensive facial contusions more prominent on the left, left peribulbar hemorrhage with slight proptosis through the left globe, lens intact. Right globe lens intraorbital contents are normal. There is fluid in the left paranasal sinus. Orbital bones are not fractured. The brain imaging showed no acute intracranial hemorrhage.

Q. Okay. So at least that did not indicate a traumatic brain injury, did it?

A. Well, when you say "at least," I'm not sure what you mean.

Q. Well -- let me rephrase.

A. No. No. Well, all right. Then ask another question.

Q. Okay. That report did not indicate traumatic brain injury, did it?

A. No, that is not true. That report just indicated no intracranial bleeding. That did show extensive trauma to the head and face with bleeding behind the eye, which is quite severe, and which indicates trauma of the force that is quite typical in causing brain damage to the underlying tissue.

The computerized tomogram is a much lower resolution imaging tool for the cranial contents, so if the MRI wouldn't show that kind of damage, the CT would be even less likely to do so.

Q. But my question is more simple than that, Doctor. The CT scan, while you think there might be better ways to observe brain damage, I think you have made that clear, or brain injury, this CT scan that was done did not indicate brain injury, did it?

A. Well, again, I think answering it any other way than the answer I gave you would lend itself to distortion or misunderstanding. I'm not going to agree with the statement that you made because I don't think it is correct. That would

be like saying an x-ray of his foot didn't show brain damage, although that would be absolutely true, that would be fallacious.

Q. Okay. But this would be absolutely true, that the CT scan did not show or indicate brain injury?

A. No, that would be fallacious to say that it did not indicate brain injury. It just showed that there was no bleeding on the brain that was visible to the naked eye.

Q. You have mentioned some other tests. We're not going to go through all those. Are you familiar with any testing, as you have indicated when you talked about different ways of doing the MRI or the CT scan, are you aware of any tests that were done, and that is the type of term I'm using, that indicated that there was brain injury suffered by Joseph Hines?

A. Neuropsychological test demonstrates the effects of brain injury, and the imaging studies as well as the descriptions of this young man's face demonstrate soft tissue injuries that are consistent with the kind of forces that cause brain damage.

Q. Okay. So you saw soft tissue injury that could be consistent with what would lead to a brain injury, correct?

A. I like the way that I said it better. That is sort of what I said. If you need to paraphrase it, you may, but that is not exactly the way I said it.

Q. The record will reflect what you just said.

A. It will.

Q. You say what you saw were the effects. In addition to the way you phrased the soft tissue and the effects that you saw through the neuropsychological, did you see any other type of testing when you reviewed the records that would indicate traumatic brain injury?

A. Any other testing besides the extensive soft tissue damage, the poor performance under a psychological assessment, the historical descriptions. Not that I can think of.

Q. Okay. Now, Doctor, is there -- in addition to what you have already said is there anything else that you either observed or relied upon that would indicate a traumatic brain injury?

A. Well, the history that I obtained and the way this man responded and reacted in his interview with me was consistent with the other histories and consistent with the other findings.

Q. Anything else?

A. His parents' description of the personality changes that occurred were consistent with what I observed and were consistent with what was described in the records.

Q. Anything else?

A. Not that I can think of at this time. There is a lot of stuff that I evaluate and a lot of things that I said in my report. I tried to be thorough in my report.

Q. Doctor, I want to make sure I understand. It's your opinion that he suffered traumatic brain injury for the reasons you have stated and those reasons included in your report, correct?

A. And other things that I have been talking about for the last 20, 30 minutes.

Q. That is what I said, from what you already said here today. Now, when you say "traumatic brain injury," are you equating that

with brain damage, because you use the term "brain damage" in your report as well.

A. Yes. Yes.

Q. So you are saying --

A. Brain injury causes brain damage.

Q. Okay. It can, right?

A. I'm trying to think of a brain injury that wouldn't cause brain damage. I suppose I could concoct some far-fetched scenario.

Q. You would also have to consider the severity of the damage that was caused by the injury?

A. Well, the severity, extent of the damage, the location of the accompanying comorbid psychiatric illnesses, other host factors that might speak to the degree of morbidity for a given damage.

Q. Okay. And when you say "brain damage," is that a medical diagnosis? Are you rendering brain damage as a medical diagnosis?

A. I don't think brain damage is a medical diagnosis. I think the medical diagnosis is cognitive and mood disorder secondary to traumatic brain injury.

Q. Okay.
A. But brain damage is just a description. You can say tissue damage. That is not a diagnosis. Tissue damage can occur from burns, chemicals, trauma, metabolic disease.
Q. I want to make sure I understand. Your diagnosis is cognitive impairment as a result of brain damage; is that fair?
A. You seem to need to rephrase.
Q. I'm not trying to rephrase. I'm trying to understand.
A. Let me finish. If you're trying to understand, why don't you listen to me then?
Q. I am listening.
A. When you interrupt me, then that --
Q. Well, you have interrupted me too, so I will stop interrupting you.
A. Then I apologize.
Q. I'm sorry too.
A. I'm sorry. You win. I will wait until you are done speaking, and then you can give me permission to speak.
Q. Well, I don't think we need to do that.
A. Okay. All right. My diagnoses are as

stated in the section diagnostic impression, and what I said was cognitive and mood disorder secondary to traumatic brain injury.

I take issue because you paraphrased, and you said well, cognitive impairment. I didn't use that language. When you say you are trying to understand, I just want to stick to the language I'm using. If you want to know what a word means, I will explain it to you.

Cognitive and mood disorder secondary to traumatic brain injury frontal lobe type means that he sustained an injury to his brain that caused damage to the underlying tissue and impairment in the function of that tissue because of that damage that affects both cognition, that is the ability to think clearly and remember, and mood, that is the ability to regulate his feelings and for his feelings to respond to the external environment without being affected by damage to the mechanism that regulates moods.

Q. Now, Doctor, if he suffered a traumatic brain injury on August 29th, 2012, would you expect to see contemporaneous problems with cognition as you have defined?

A. You may, or there may be a delay to the onset of problems with cognition, depending upon the nature and location of the brain injury. Sometimes these disorders take several days or even several weeks to evolve and to manifest themselves completely.

Sometimes in a case like this where there are soft tissue injuries, there is pain and stitches. The effects of those injuries and medications used to treat those injuries can often mask or impair the manifestation of underlying brain damage, so the condition may not manifest until some time later.

Q. You don't address that in your report, do you?

A. I wasn't asked anything about that. That is one of those things that when you asked if these were all my opinions, I said I tried to be complete, but I didn't know what you were going to ask.

Q. Yes. Okay. Again, I'm just -- my question is you didn't indicate that in your report for whatever reason, you weren't asked or whatever, but it's not included in your report?

A. No. I didn't address that specific issue in my report because I understood that I had an opportunity to discuss these matters in a couple of different forums.

Q. If somebody suffered traumatic brain injury on August 29th, 2012, would you expect to see a decrease in academic performance contemporaneously?

A. If somebody -- are we talking about -- this is a hypothetical question?

Q. Yes. Let's do a hypothetical.

A. You may or may not. It depends on how challenging the academic test was, whether it was ever learned or not, whether the instructors were understanding or more demanding and whether there were other supports. Academic performance is not solely affected by cognitive function.

Q. What about academic performance in college? Let's use college as an example.

A. It's not solely affected by cognitive disorders. There are a number of factors that go into it.

Q. But would you expect to see some decrease in academic performance as a result of a

traumatic brain injury?

A. Excuse me. Could you read back my answer to that question the first time it was asked?

(The requested portion of the record was read by the reporter at 5:53 p.m.)

"A. You may, or there may be a delay to the onset of problems with cognition, depending upon the nature and location of the brain injury. Sometimes these disorders take several days or even several weeks to evolve and to manifest themselves completely. Sometimes in a case like this where there are soft tissue injuries, there is pain and stitches. The effects of those injuries and medications used to treat those injuries can often mask or impair the manifestation of underlying brain damage, so the condition may not manifest until some time later."

A. That is my answer. That is the first time you asked it, and it's still the answer.

BY MR. MANGAN:

Q. Let me ask you. In your report at page 7 your opinion -- let me just start the third

paragraph. I believe it's the third sentence. You stated, "His illness is complicated by the fact that he sustained brain damage in the assault, and his neurological assessment demonstrates impairments that are not consistent with his prior educational achievements." You stated that, right?

MS. GLAZER: Objection. You didn't read it correctly.

A. You didn't read it correctly.

BY MR. MANGAN:

Q. Why don't you read it then?

A. That sentence?

Q. Yes, please.

A. "His illness is complicated by fact that he sustained brain damage in the assault, and his neuropsychological assessment demonstrates impairments that are not consistent with his prior educational achievements."

Q. Now, you wrote that?

A. Well, I dictated it.

Q. Okay. You read it accurately, right?

A. Yes, I did.

Q. Okay. Explain to me what you mean by,

"Not consistent with his prior educational achievements." What do you mean by that?

A. Well, he gave me a history, and I believe it was endorsed by his parents, that he graduated high school with a 3.87 grade point average. Then he told me he has a 2.0 or 2.1 grade point average. He said he did poorly as a freshman, was on probation and improved his performance in his sophomore year racing his grades to a 2.3 or 2.4. But after the assault he had problems concentrating, problems remembering.

Again, academic performance is affected by more than simply cognitive abilities. It's not unusual for a kid who does well in high school to go away to college and go to a more stimulating environment and not perform as well.

But certainly the kind of struggling and the kind of performance that is described on this neuropsychological assessment is not consistent with someone who would get over a 3.5 in high school.

Q. Did you review his academic record, whether it be high school and/or college?

A. No, I didn't.

Q. When you talk about his prior academic achievements, is it fair to say that you relied entirely on Joseph Hines telling you what his academic achievements had been and his parents had told you they had been?

A. I'm sure the judge will decide what is fair, but what I did was take a history, and I relied on the history that was taken from the patient and endorsed by his parents.

Q. Okay. That is the only thing you relied upon to make the statement about his prior academic achievements?

A. Well, I didn't see his academic record.

Q. Okay. And I'm not trying to be difficult. You told me you got it from the parents; you did not see his academic record. Did you see anything to indicate -- anything else? I'm trying to clarify.

A. I didn't see anything else that made reference to his grade point average unless -- hold on for a second.

Q. I'm not asking just about his grade point average. I'm asking about prior educational achievements.

A. No, I can't think of anything that described prior academic achievements.

Q. Okay. And Doctor, in that same sentence you indicate that, "His illness is complicated by the fact that he sustained brain damage." Is it your belief that it is a fact that he sustained brain damage, or is that your opinion?

A. Well, let me answer as best I can. It's my conclusion within a reasonable degree of medical certainty based on the things that we have been discussing all evening that that is what happened.

Whether it's a fact or not I believe is up to the finder of fact in this matter, not to anyone in this room. But to advise the finder of fact, I would tell the finder of fact in this matter that that was my opinion within a reasonable degree of medical certainty.

Q. But you did call it a fact. I didn't make that up, did I? That is your wording?

A. I refer to it as a fact. Whether it is accepted as a fact in a proceeding such as this, I was only advising his attorney of my medical

findings. But in these proceedings whether or not it is a fact or not is up to the judge or the jury.

Q. Okay.

A. But again, that is my conclusion, within a reasonable degree of medical certainty that I'm comfortable calling it a fact as someone who is not a lawyer.

Q. And then Doctor, going again to the same part of your opinion part of the discussion, the same page, page 7, and I will read it. If I read it wrong let me know.

A. Then I will have to read it.

Q. "A careful review of his psychosocial history reveals no other factors capable of causing a pattern of decompensation of this type other than a response to injuries sustained in the assault." Did I read that correctly?

A. I think so, yes.

Q. And you did state that?

A. That is what my report says, yes.

Q. Okay. I just want to make sure I understand some things. When you say, "A pattern of decompensation of this type," I'm just trying

to find out are you talking about cognitive functioning? Are you talking about PTSD? Are you talking about both? Are you talking about other things? You talk about a pattern of decompensation of this type. Can you tell me what you meant by that?

A. Well, that is like three questions.

Q. Well, okay. Let me make it one question.

A. Yes. It will make it easier for me.

Q. Tell me what you meant when you stated the term, "A pattern of decompensation of this type."

A. A pattern of decompensation of this type means a summary of all the patients' signs and symptoms and everything that is described in the medical documentation that I have reviewed. So looking at the history that he provided to me of what happened to him, the history of how it affected him, the endorsement that his parents gave and the personality changes and emotional changes and behavioral changes in him, the soft tissue swelling and the bleeding behind his eyeball and all of the signs of facial trauma and

everything else I include in my report, that is what I mean by a pattern of decompensation.

It's all the symptoms, all the complaints, all the findings and all the descriptions in the other medical reports, including the neuropsychological assessment, the collateral history from the mother, the way they described how he looked in the hospital the day after the assault.

Q. Taking that answer into consideration, it's your opinion that no -- absolutely no other factors are capable of causing that pattern of decompensation?

A. I don't recall using the term "absolutely" in my report. If you had a need to put that in there --

Q. I didn't say "absolutely," Doctor. Let me read it to you.

A. I didn't say "absolutely." Did he say "absolutely"? Maybe you can read his question for the record just so we can both be clear.

Q. No. You don't need to read the question back. I want to ask you. You stated, "A careful review of the psychosocial history reveals

no other factors capable of causing a pattern of decompensation." Is that your accurate opinion?

A. That is my opinion within a reasonable degree of medical certainty.

Q. I just want to clarify. No other factors can cause the pattern of decompensation that you believe occurred?

A. No other factors that I was able to find in his history. When you say no other factors, I mean if he was in a car accident, he could have had similar problems, or if he was injured under some other circumstances, but we have no history that he was. If he was born with certain congenital problems, well, that really wouldn't present this pattern, but if he had some congenital problems that were causing the impairments that I noted and the kinds of things that were described in the neuropsychological assessment, they would have manifested themselves in other settings, and they haven't.

Q. So just to make it very clear, and you have already said you are limiting it to what you know and what you have included in your report, and you are aware of no other factors capable of

causing a pattern of decompensation of this type?

MS. GLAZER: Asked and answered.

MR. MANGAN: I don't think it was.

A. Well, with the way you asked it, the only thing I can tell you is that after taking what I considered to be a thorough and detailed history, after taking collateral history from his mother and from his father, after reviewing the medical documentation I have been provided, and including the items in 1 through 5, there were no other historical factors that would explain this pattern of decompensation other than a reaction to brain damage sustained in that assault.

Specifically the fact that the soft tissue injuries represent the effects of forces that are capable of causing brain damage in the areas that typically cause reactions to brain damage of this type, and assaults of this type such as he described are the kind of assaults that are associated with posttraumatic stress disorder.

BY MR. MANGAN:

Q. When you say, "such as he described," what do you mean by that?

A. Well, from the history that he gave.

Q. Do you recall the history that he gave of the actual incident?
A. Yes, on page 1 and page 2 of my report.
Q. And using that report do you remember what he said actually happened to him?
A. Do you want me to read from my report again?
Q. You don't have to read the whole report.
A. What sentences do you want me to read?
Q. Why don't you take a look? Do you remember exactly what he told you about the alleged assault?
A. Well, I don't know that this was a verbatim transcription of what he told me, but I tried to be as close to verbatim as possible. But what he said was that he and his friends were speaking when to officers, a male and female, rode by on bicycles. The officers passed them, turned around --
Q. Okay.
A. Is that not what you want me to do?
Q. I don't want you to read the whole thing. I'm asking about the alleged assault.

Let's limit it to that.
A. Tell me what sentence to start reading, and tell me where to stop.
Q. If you want to look at it, it says that, "He," meaning Joseph, "states the officers then grabbed his wrist to restrain him and handcuffed him." I'm sorry. It's on page --
MS. GLAZER: Do you want him to read it, or are you going to read it?
A. Do you want me to read it, or do you want me to read it? It's already an exhibit, so I assume it's in evidence.
BY MR. MANGAN:
Q. I'm limiting it to the actual assault which you have used a lot, the term "assault." The second full paragraph that Joseph Hines told you that he was tackled by both of the officers, he was taken to the ground and handcuffed. He states that was the last thing he remembered.
A. Until he woke up with his eye swollen shut, bruises on his face and his face was burning, which he inferred because they attempted to subdue him with mace or some sort of pepper spray.

Q. Do you use the term, "When he woke up"?
A. No, I don't.
Q. I don't see that in there.
A. That was his next recollection.
Q. The next thing he remembers?
A. When I say something, you seem to have to have a need to put it in your own words.
Q. No. I have a right to ask.
A. Sure. But that isn't what I said. If you are asking me what I said, what I said was that was his next recollection. If we are going to be that picky about what word I put in my report, then I'm going to be very precise in using the words I use.
Q. We are going to be picky, Doctor, because you gave a report, and I have every right to ask you questions.
A. I'm not disputing your right.
Q. When you use a word like "awoke" and I ask you that isn't in your report, that is all I'm trying to find out. If that is being picky, I'm sorry.
MS. GLAZER: Do you want him to read the exact term in his report?

A. If you want me to read the report, tell me to read the report.

BY MR. MANGAN:

Q. No. That's not the way we are doing it.

A. I'm trying to figure how we are doing it so I know what you want to know.

Q. Well, I don't know why you are trying to be so difficult, but that's fine.

A. I beg your pardon. I beg your pardon.

Q. I think you are being very difficult.

A. Well, you know, when in a conversation with someone difficult, it's very, very important to make sure that the difficult person isn't likewise engaged. I'm really trying to cooperate and answer your questions, but I have to be precise. You have a job to do. I have a job to do. I have to be precise in expressing myself.

I don't want anything I say to be easily distorted or misinterpreted, taken out of context or used in a manner in which I didn't intend it to be used, so I'm trying my best to be precise. I don't mean to be difficult, but when I say something and then you give a very long speech

and you paraphrase what I say, I can only say that that is not what I said and that is not the way I said it.

Q. Well, we disagree on that, Doctor.

MS. GLAZER: You started out asking him to read the report, and then you started reading it. I'm still trying to get what your question is.

MR. MANGAN: I think I'm trying to make a question.

MS. GLAZER: Let's start over and make a question.

BY MR. MANGAN:

Q. You used the words, "when he awoke." The report does not include the words, "when he awoke."

A. I already answered that.

Q. No, you didn't.

A. We can go back to the record, but I did. I said that I did not use the word "awoke" in my report. I used the term "his next recollection."

Q. Okay. Now, Doctor, is there any other -- in addition to what you have included in your

report and what you have already said, are there any other opinions you rendered with relation to your opinion that he suffered brain injury resulting in cognitive dysfunction, however you termed it in your report? I'm not trying to use a different word.

A. I've tried to be as thorough as I can, and I have tried to answer every question you asked me.

Q. Okay. I want to ask you about the neurological assessment or the neuropsychological assessment, okay?

A. Ask away.

Q. I'm looking at page 5 of your report.

A. Page 5 of my report.

Q. Yes. The second full paragraph. You say -- let me just go through it. I will try not to go too fast. "University of Michigan performed a neuropsychological assessment. The patient's history is consistent with that provided to me. The patient passed the TOMM, which would indicate that he was making good effort. Full scale IQ was 109 with a verbal IQ of 116 and a performance IQ of 102. The patient's skills within executive

functioning domains were variable. Working memory was in the high average range. Mental arithmetic was average. Auditory and Visual Continuous Performance Test was average to high average. Performance was impaired on measures of vigilance, sustained attention. On a task of cognitive flexibility and resistance to interference his performance was in the low average range." Did I read that accurately?

A. Yes.

Q. You included that in your report, correct?

A. I did.

Q. Now, is that indicative in your opinion of cognitive impairment or cognitive functioning problems?

A. It's indicative of impairment in frontal lobe functioning, and the pattern of strengths in certain domains and weaknesses in others is consistent with an acquired deficit rather than something that is congenital or inborn.

If it's congenital or inborn, then all the domains should vary within concert, but

because of this variability and because of the impairments in the areas of executive functioning and the history of all the trauma around his eyes, especially his left eye, those are consistent findings. Those are domains that are served by the brain areas that are retroorbital or behind the eyes.

Q. Now, are you aware, based on your review of the records, of any baseline upon which you could compare this neuropsychological assessment with anything else?

A. What I understand is that there is no evidence anywhere that there was any premorbid neurocognitive dysfunction.

Q. Well, let me be a little more specific. Maybe it's too general. The IQ score that is indicated in here, are you familiar with any other IQ testing that you looked at or saw that would indicate that that is different than what it was prior to the incident of August 29th, 2012?

A. So the question is am I aware of any IQ score that was generated before the assault or have I seen any IQ score and compared it to the University of Michigan findings. No, I haven't

seen his educational records, but I want to be careful in answering that question because I don't want to endorse the fact that an IQ test can be reasonably compared to a neuropsychological assessment.

An IQ test doesn't test exactly the same things that a neuropsychological test would evaluate. So at the risk of that being an invidious comparison, I don't know of any IQ testing that exists.

Q. For any of the other items, for lack of a better term, listed in that paragraph, are you aware of any prior testing that would give you, again, for lack of a better term, a baseline to determine if there is a difference pre August 29th, 2012 and post August 29th, 2012?

A. As far as I could determine, there is no evidence that any of those determinations were undertaken prior to the assault. Again, I want to be careful in answering that because I want to make sure that at some later point I'm not asked to compare an educational battery or tests that were given for other purposes or academic purposes to a neuropsychological assessment because that

would be an invidious comparison.

Q. But you didn't see any of those?

A. There is no history of any description of any cognitive impairment prior to the assault.

Q. That wasn't my question. My question was you didn't see any other, I think you used the term educational -- I'm sorry.

MR. MANGAN: Could you read that one back, his answer to that?

(The requested portion of the record was read by the reporter at 6:16 p.m.)

"A. As far as I could determine, there is no evidence that any of those determinations were undertaken prior to the assault. Again, I want to be careful in answering that because I want to make sure that at some later point I'm not asked to compare an educational battery or tests that were given for other purposes or academic purposes to a neuropsychological assessment because that would be an invidious comparison."

BY MR. MANGAN:

Q. So my question is, trying to use your terms, you are not -- you did not see or are you aware of any other educational battery or test

when you were doing your report?
A. And I think three times in response to your questions I said that I haven't seen his school records, so I wouldn't be aware of any educational testing.
Q. There could be even beyond school records. I'm asking for any other tests.
A. Like where?
Q. I don't think you said it three times, but that's fine. Okay.
Now, let's go to posttraumatic stress syndrome, okay or disorder, PTSD, posttraumatic stress disorder, correct?
A. Is that how we refer to the disorder? To answer your question, yes, the proper terminology is posttraumatic stress disorder.
Q. You did determine that he is experiencing posttraumatic stress disorder?
A. He suffers from that condition.
Q. Okay. Do you conclude that based on the symptoms that you have learned that he is experiencing?
A. I conclude it based on the history I have obtained, collateral history from his

parents, observations that I made during my mental status examination, my experience with diagnosing those conditions and my review of the documents that I have been provided.

Q. Okay.

MS. GLAZER: Tim, off the record.

(Recess taken at 6:18 p.m.)

(Back on the record at 6:21 p.m.)

BY MR. MANGAN:

Q. Doctor, we were talking about PTSD.

A. Yes.

Q. We can use that term for posttraumatic stress disorder, correct?

A. Sure.

Q. And you explained how you arrived at that conclusion, I believe, and the record will reflect that. I wanted to ask you then, you indicate in your report at -- let me see. I have it here. Do you ever in your report -- or did you render an opinion as to the severity of PTSD? Is that something doctors do or not? That is two questions.

A. It is.

Q. Let me back up. Do doctors identify

severity of PTSD or not?

A. A doctor may comment on severity. Usually issues of severity are addressed in Axis 5, highest level of functioning in the prior year where a global assessment of function score is given. In this case I gave a score of 50, which is a significant impairment. That impairment is a combination of the effects of the cognitive and mood disorder secondary to traumatic brain injury and posttraumatic stress disorder.

Furthermore, the determinant of morbidity in posttraumatic stress disorder has something to do with its duration. I saw him in 2014. This incident occurred in 2012. Generally if PTSD lasts for longer -- symptoms last for longer than six months the situation is said to become chronic -- or the condition is said to become chronic. Literature supports the finding that if symptoms are present at six months, they are likely to be present at a year and five years.

Q. In fact, in your report at page 7, paragraph 3, you do say, "The fact that he remained symptomatic some two years after this incident -- or the incident portends a poor

prognosis."

A. That's right.

Q. You did have a poor prognosis for him?

A. I do.

Q. Did you consider any other of the prognosticators for prognosis -- any other factors in the DSM that talk about prognosticators?

A. Any other factors that talk about prognosticators. I don't know what you mean.

Q. I don't either.

A. We are in agreement here.

Q. Perhaps we will withdraw it. You are familiar in DSM-5 there is some discussion about factors having to do with prognosis; is that accurate?

A. Yes, DSM-5 is still relatively new. Although it has been adopted, it hasn't been formally and ultimately adopted. We are in the process of -- we are in the early stages of evaluating it, but yes, it does speak of prognostic indicators.

Q. And you did use DSM-5?

A. Well, no. This is more of the convention that is suggested in DSM-4. As I said,

DSM-5 is still evolving. I considered some of the changes and alternatives that are suggested in DSM-5.

Q. You used the fifth axis in your diagnosis?

A. Yes.

Q. Which is in DSM-5, but not DSM-4?

A. No. All of the Axes are in DSM-4 and 5.

Q. There is a fifth?

A. Yes.

Q. There always was?

A. Yes. Not always. Not in DSM-2.

Q. Did you consider any other, besides the duration which you have referenced --

A. I --

Q. Let me finish. Besides the duration did you consider any other prognosticators? For instance, that he didn't have problems before the incident, for instance, that he has a family, that he apparently has support, for instance, that he is continuing to go to college, things like that. Did you consider any other prognostic indicators? That's a better term, I think.

A. Well, I want to be careful in endorsing that those are reliable prognostic indicators in spite of what the DSM describes. The DSM is only a guideline. But yes, I did take into the fact that he had concerned parents. I had a chance to interview and meet the parents and take a collateral history from them. I did know he manifested a very traditional work ethic and traditional education ethic.

I think that he conveyed to me in sentiment, and I think he articulated to the University of Michigan people, that his -- part of his reaction to this was to become earnest in his schoolwork, earnest in his resolve to pursue his education.

I also took into account that he is at a very -- he is a member of a very vulnerable risk group for developing post traumatic symptomatology in that he is a young adult, that there is likely to be greater morbidity in someone who has a positive blood alcohol level at the time of being traumatized both on the effects of brain damage and the effects of trauma, also that there were physical effects to this trauma and that the

situation was humiliating and physically and emotionally painful to him. But yes, I did consider other factors than just the duration of his symptomatology.

Q. Okay. Are you familiar with the therapy or the treatment that he is receiving from Ohio State University?

A. Yes.

Q. Did you review those records?

A. No, I don't believe I have seen those records.

Q. So you can't make a determination as to whether or not he has been responsive to therapy or nonresponsive to therapy?

A. Oh, I can tell that his response to therapy has been less than robust because of the degree of symptomatology that he manifests two years later in spite of having received treatment.

Q. But you haven't reviewed the records from the therapist to indicate whether or not they have seen progress or a lack thereof?

A. Well, I haven't seen the records, and I already said that I haven't seen the records.

Q. Right.

A. I haven't seen the records to see if that was addressed in the records either.
Q. Okay. Would that be significant to you, to see how somebody is responding to therapy when you are making a prognosis?
A. Well, I want to be careful in answering that because in looking at his condition and listening to the presence of symptomatology, I think I can evaluate his response to therapy. I think what you are asking me would be better focused on what his therapist thought of his progress. And again, regardless of what his therapist thinks of his progress, he remains symptomatic, and he remains significantly troubled with a significant impairment in his ability to function attributed in part to the diagnosis of posttraumatic stress disorder. His symptoms are still there.
Q. So you don't know what his therapist feels is his response to therapy?
A. I don't know what they think or have written. I haven't talked to hem.
Q. You don't know whether or not they were observing cognitive impairment or not? Do you

know that?

A. Well, all I can say is I can't tell you if they have seen that or addressed it because I haven't seen those records, and if they are providing him cognitive restructuring and every action of the typical modalities of treatment for posttraumatic stress disorder, they may not be focusing on cognitive impairment, or they may not have had the advantage of looking at the University of Michigan neuropsychological assessment records, or they may not have had the benefit of seeing the extensive soft tissue damage to his face and eyes that accompanied this assault. I can't say what their opinions would be.

Q. You can't say whether or not they at OSU see the PTSD as more severe or less severe than you see it?

A. I haven't seen those records.

Q. Okay. Now, Doctor, I want to -- I hope quickly, but we will see.

A. I will do my part.

Q. I just want to go through.

A. I'm talking fast.

Q. Again, going back to your report, you have been through what you did for the report. I think it is clear in your report, but you did an exam of Joseph Hines, correct? That was number one -- or not number one, but that was one of the things you did as part of your evaluation in order to produce the report.

A. I did a psychiatric evaluation.

Q. Okay. How long were you with Joseph Hines to do the psychiatric evaluation?

A. A couple of hours.

Q. A couple of hours. And you saw him alone?

A. I did.

Q. And you think it was two hours, three hours?

A. I said a couple of hours. It was about two hours, maybe an hour and 45 minutes, maybe as much as two hours and 15 minutes. I didn't time it.

Q. Okay. And you conducted a mental status examination?

A. I did.

Q. That consists of what you have included

in your report there at pages 5 and 6, correct?
A. That is recorded in my letter to Miss Glazer.
Q. Which is what I'm calling a report?
A. That's right.
Q. You are not calling it a report?
A. A report.
Q. I'm just asking. I didn't know if there was another report or if I was calling it wrong.
A. No.
Q. Then during that time you took a history from him?
A. I did.
Q. That is pretty well documented in there as well. Did you assess the credibility of Mr. Hines in reporting his history?
A. Well, I want to be careful in answering that. I don't want to give you the idea that a psychiatrist just acts as a passive conduit for what a patient tells them. A psychiatrist understands that history has inherent distortions just like you will go back to your residence tonight, and you and your colleague will discuss

what happened here. I will talk to Miss Glazer's assistant or I will go home and talk to my wife. Our accounts might vary and would be different. Neither one of us would be lying, but they would be subjective accounts.

History is a subjective account of what happens. I took it that way. What I found was there were no indications of malingering or no indications of a tendency to enhance or embellish his degree of suffering. He didn't use superlatives or hyperbole. He didn't raise spontaneous concerns about authenticity. He didn't have any gross distortions in thinking or his account of events.

But we have already said several times that I wasn't there and I didn't see what happened with him and the police officers.

Q. Okay. Did you discuss Joseph Hines' responsibility in relation to the incident?

A. What kind of responsibility are you talking about?

Q. If any. That is what I'm asking. Did he or you talk about what, if any, responsibility he had in what occurred?

A. Well, let me put it this way: I will draw your attention to the second paragraph, first full paragraph, on page 2, and he was telling me what happened. I was taking a history, and he said when the officers passed them, they turned around and came back and asked the group about an empty Four Loko can that was on the ground. They asked whose it was, and the patient said that it wasn't his, and he said that he didn't know whose it was, but he did acknowledge to me that he, in fact, did know whose it was. I don't know that he has any obligation to tell the officer whose can it was. I don't know that he has any obligation or responsibility to disclose that information on casual questioning.

Then they asked him for his identification. He said he had none, even though he acknowledged that he did. Again, I don't know that he has any responsibility or any obligation to produce identification for a police officer in a casual encounter like this.

I know that police officers don't like having citizens respond to them in that manner, and that often heightens their aggressive

responses, but we did discuss how he saw himself, what he saw that he had to do and what he saw that he didn't have to do.

Q. You are generalizing about officers. You don't know the officers involved in this case or what happened in this situation?

A. Let me be careful in answering that. Although I don't know the officers in this case, I have evaluated over 5,000 police officers over the last 30 years, and I know a lot about police officers as a group, but I don't know these officers. I haven't had an opportunity to evaluate them. Miss Glazer hasn't asked me to do so as of yet, but she might.

I haven't seen their records or whether they have been the object of other citizens' complaints or other civil suits based on their conduct.

Q. In addition to your mental status examination and the history taking that you have talked about, did you do anything else with Joseph Hines when you were with him? I don't know if you would do testing or neuropsychological testing or anything like that. I don't know the answer to

that. I'm just asking.

A. No. I conducted a psychiatric evaluation that consisted of an interview and a mental status examination. I took, as we have said several times this evening, I did obtain collateral history from his parents, primarily reviewing the history that he provided to me and asking him if it was consistent with the observations or not, and then I reviewed the documentation that was provided.

Q. Okay. Now, I just wanted to ask you this: Did you take into consideration if there was anything that could compromise Joseph Hines' ability to accurately report to you?

A. Well, I don't know about issues of accuracy, but he did say, for example, he was taken to the ground in handcuffs. That was the last thing he remembered, and then my next sentence is he regained consciousness. So he didn't have any recollection from the time he was handcuffed and taken to the ground until he woke -- until he regained -- I won't say woke up because we discussed that. I will say until he regained consciousness and found his eyes were

swollen shut, his face was bruised and his face was burning. I don't know if he knew or just inferred that he was maced.

But in terms of trying to determine his accuracy, I did look at some of the things we discussed before, whether he had a tendency to embellish his complaints, and I would look at that by whether he over-specified his symptoms, whether he used superlatives and hyperbole, whether he raised spontaneous concerns about the authenticity of his narrative, whether he endorsed the fact that his treating therapists and doctors understood him better than other doctors, and you know, all of those things contribute to my assessment.

No psychiatrist is a lie detector, but there were none of the indicators that accompany patients who embellish or distort grossly.

Q. I'm not just talking about embellishing or distorting. I'm asking the ability to accurately report as well. Do you understand that?

A. Well, the only impairment that I determined inability to accurately report was the

time that he described the lapse of consciousness or the lapse of recollection.

Q. You knew he was drinking alcohol that night, don't you?

A. Yes. He had a blood alcohol level of .7, which is below the legal limits of intoxication in Michigan.

Q. You that was four hours after the incident occurred?

A. I do.

Q. What would that, based on your knowledge and experience a .07 four hours later can you extrapolate, approximately to what that would mean four hours earlier?

A. It probably would have peaked at .8 or .9. Alcohol is a zero or metabolism drug. A certain amount is metabolized per hour rather than a certain percentage of the patient's load. So that would probably peak at .8 or .9. Differences would be very moot.

Again, the big issue here is that patients who are under the influence of alcohol tend to have greater morbidity when they sustain head injuries than patients who do not. I

wouldn't expect a blood alcohol level of point -- what did I say .07?

Q. .07.

A. It's confusing because there are two ways to report that. That would be .07 or 70. But even a .10 blood alcohol level wouldn't cause impaired recollection.

Q. Okay. Would it -- let's say that it was .8 or whatever, .9, you don't know that, I don't know that. Would that affect his judgment that night?

A. Well, it may. There is no indication that it would have of necessity, but it might.

Q. Okay.

A. Again, even .1 is really quite low.

Q. Okay. Your report indicate that he had a few energy drinks laced with alcohol. Is that what he reported to you, or is that your reporting?

A. I'm looking to see exactly how he described it to me. He said he had some -- he said the incident occurred at about 10 p.m. He had some alcohol that was combined with an energy drink.

Q. Can you read exactly what it says, because I can't find it, Doctor?
A. Here. On the bottom of page 1.
Q. Okay.
A. "He and his friends had a few energy drinks laced with alcohol."
Q. Was that his report to you?
A. Yes.
Q. What did you take that to mean?
A. That he took Red Bull or something, something like that, and then they poured some alcoholic beverage in it.
Q. Did he tell you that?
A. I don't have a verbatim transcript. That was my understanding. Whether it was based on his exact wording or based on my conclusions after discussing it I can't say.
Q. He also indicated to you in here somewhere, and I can't find it, that he was drinking Four Loko.
A. I think the only description of Four Loko was that there was a Four Loko can on the ground, and he said he didn't know whose can it was. In fact, it belonged to a friend of his. He

didn't say that Four Loko was the drink he was drinking.

Q. You don't know if he was or was not drinking Four Loko?

A. I understood that he was drinking an energy drink that had alcohol in it.

Q. You are not sure if it was or wasn't Four Loko?

A. He didn't specify Four Loko.

Q. Are you familiar with Four Loko?

A. No.

Q. No experience or knowledge --

A. No.

Q. -- of Four Loko?

A. Never tasted it.

Q. I'm not just asking you. Based on your experience in working with people --

A. I don't think we have it up here in Michigan. We may.

Q. Now, did you also take into consideration, and I'm asking about things that could affect his ability to accurately report to you, and I'm not just talking about making things up or lying or anything like that or embellishing.

Did you take into consideration the fact that he is involved in a lawsuit for which they are seeking monetary payment? Did that --

A. Well, I want to be careful in answering that question. I did understand because he was referred to me by Ms. Glazer that there was a possibility that this would proceed to litigation. In talking with him he understood that he didn't file a lawsuit; his parents had. I think in talking to his parents I think they were outraged that, at least by their understanding, the police had unnecessarily abused this young man.

This man, this young man, was more affected by the fact that he wasn't the same person, he couldn't get things going, and he was haunted by the memories and recollections and reactions by what happened to him.

I have seen people. I have done quite a bit of this work. I'm a board certified forensic psychiatrist. I have been at this for a long time. I have seen some people who come in, in the context of a lawsuit, who have a real chip on their shoulder. That is, they have a lot of feelings of resentment that they either attempt to

hide or that they express to varying degrees. I didn't see that in this young man.

Q. Okay.

A. But I did consider that possibility.

Q. Okay. And did you take into consideration the possibility --

A. Actually, Four Loko was discovered by three graduates of Ohio State University.

Q. Okay. Let's not do that now because we are on my time here, so we have got to keep moving.

A. I thought you would be proud.

Q. So did you take into consideration the fact that there -- he had been involved in a criminal matter for which he was found guilty? You were after that I know. Did you consider his criminal involvement and conviction in any way could possibly affect his ability to accurately report?

A. Well, I want to be careful in answering that. He was pretty candid with me about the fact that he and his friends were drinking alcohol. He was candid with me that he knew whose can it was, that when the officer asked him for his

identification, he said he had none. He told me that he had been charged with a number of things and that he -- and that everything was dropped except for a charge of littering, and that he had some assurance that his record would be expunged after a year.

In Michigan we have a law called the Holmes Youthful Trainee Act that allows for that. I don't know what you guys do in Ohio. He told me that when he filed his lawsuit that he refused to expunge his record. Whether it's criminal or not and the degree of criminality involved I think is a matter of question.

Q. Whether that is true or not, you don't know?

A. As I said, I think it is a matter of question, and it's for the finder of fact. I did consider this was a police encounter and that this was a young man who didn't fully cooperate with the police. He didn't give me any indication that he initiated any aggression or any physical approach.

Maybe the officers will have a different account, and the finder of fact will

have to consider what their account is, what his account is, take into account what we are finding in places like Cleveland and Ferguson about how the police approach young African-American men. Those are all for the finder of fact, but I did consider those issues.

Q. Did you consider the possible implications for him when reporting to you for problems in Ohio State University for drinking under age?

A. Oh my God. If the university could hold drinking under age against a college student, colleges would be about half of their size in our country. I think alcohol use is a common experience for college-age youth, for under-age youth.

I did consider all that because he told me he had been charged with a number of things, multiple charges, and I don't know if they were resisting arrest or possession, public intoxication or whatever. But he told me they were all dropped, and it's been my experience that absent any chronic pattern of offense or chronic behavioral difficulties universities trying to be

understanding, and they tend to adhere to the principle of diversion. They are more likely to divert a college student who gets in trouble or who possesses alcohol into some corrective action rather than to take a punitive stance.

All that being considered, I did take into consideration the things that he described and the circumstances that he described.

Q. You have no knowledge of OSU's response or implications related to underage drinking for students, do you?

A. I haven't seen their policy specifically. I would be surprised if they were punitive rather than diversion, but I have been surprised before.

Q. Did you take into consideration his own parental approval as it relates to drinking and being in trouble when you were considering whether or not he did or was able to accurately report?

A. Given the fact that I had an opportunity to talk to his parents and see that they were more understanding than punitive or draconian in their response, but yes, I did consider that maybe he was afraid of his parents

finding out what happened or afraid of his parents disapproving of the actions that he took. That didn't seem to be a factor, but I did consider it.

Q. As part of your evaluation and letter or report, in addition to what you have described what you did with Joseph Hines and your review of the records, you also took a collateral history from the mother and the father?

A. Right.

Q. Did you make any assessment or determination of credibility for either one of them?

A. I didn't find any impairment in their credibility. They didn't seem -- many parents would say my child wouldn't do anything like that. They didn't seem overprotective or unrealistic. They didn't seem to idealize their child, their young adult child. They did seem troubled by what happened to him, but I didn't consider it to be inappropriate.

Q. If we could just take a couple minutes and my Co-Counsel and I can talk, I think we might be close.

(Recess taken at 6:51 p.m.)

(Back on the record at 7:00 p.m.)

BY MR. MANGAN:

Q. Okay. Doctor, I have a few more questions I wanted to ask you.

A. All that time you spent I hope you came up with something.

Q. We will see now, won't we? Have you in your practice done any research or investigation which related to football-related injuries, concussions? It's all in the news now. Have you looked into that as a possible cause for brain injury or concussions or things like that?

A. Well, the kind of repetitive trauma encephalopathy that occurs to football players is something that occurs over a great length of time. It's not common in high school athletes or college athletes. It's more common -- and we don't see that in people who played sports in high school and college in a limited manner even if they made a college team.

It's more something you see in professional athletes who play well into their adult life and play repeatedly over a span of

years. So a young man of age 22, even if he played football in high school and played college football or played soccer and head butted the ball, I wouldn't expect to see the kind of effects that were described in the neuropsychological assessment.

Furthermore, it would be very unusual for a football injury, for an athlete wearing a helmet, to have the kind of effect that the facial bruising, retroorbital, retrobulbar hemorrhage would cause, the soft tissue swelling, the lacerations to the eye. Those speak to more discrete focal trauma in one episode. So any athletic injuries would pale in comparison to that.

Q. Anything else you considered in relation to football and conclusions or brain injury?

A. Again, I'm not sure what else there is to consider. I considered the kind of repeated traumatic encephalopathy effects, but again, those don't manifest until 40s or 50s, so that is not consistent with what we are seeing here.

Q. Did you ask or determine whether or not

Joseph Hines was involved in any athletic activities, whether it be in grade school or high school?

A. I don't have any history of him having been involved in any of that high intensity competitive athletic activities.

Q. Okay. Now, in your report, Doctor, you talked about past medical history at page 4.

A. I do.

Q. I note that you indicate that he denies the use of street drugs, but he did experiment with marijuana as an adolescent?

A. Yes.

Q. What did you find out about that?

A. That he had a few occasions where he was exposed to marijuana, that his use wasn't compulsive, wasn't regular, wasn't ongoing.

Q. When you say exposed to, you don't mean him being around it; you mean him using?

A. He experimented and used it on a handful of occasions.

Q. He told you on a handful of occasions when? When he was in high school or college? Did he tell you?

A. I believe in high school.
Q. Do you know if he ever got in any trouble for the use of marijuana in high school or grade school or college?
A. I don't have any history of that.
Q. He didn't tell you that?
A. Here we go again.
Q. I'm just asking.
A. I have no history.
Q. When you talked to the family and to him, you were given no history of that?
A. That's right.
Q. I don't think we are that far apart.
A. I'm trying to be precise.
Q. Yes, and so am I.
A. But I like the way I say it when I answer the question. If you have to repeat it using different words, I might not go along with it.
Q. I don't think the record will necessarily reflect that is the way it has been, but we will see. You also note in there in the personal history he attended Jackson High School, and you give the 3.87 GPA. Top of the page on

page 4.

A. Yes, I see.

Q. You also say he was never suspended.

A. That's right.

Q. Would you put that in every report you have of a young man, he was never suspended? It seemed odd to me, and that is why I'm asking.

A. I pretty much ask everyone.

Q. You ask essentially everybody if they have been suspended from high school, essentially everybody?

A. Well, I found that it's not worth asking kids who go to parochial schools because they don't suspend you in parochial schools. They kick you out.

Q. So you would include, though, the suspension in there?

A. Yes.

Q. Did he tell you that he had been in any trouble in school short of suspension or towards suspension or any disciplinary matters?

A. I don't recall the specific answers he gave, but I understood that he was generally well behaved. I didn't take any history of any unusual

disciplinary encounters short of suspension.

Q. Okay. And that is why I was asking, because when you put it in there, I was curious to see if there was something short of suspension that occurred.

A. I don't want to say this kid never got a detention.

Q. You were hired by the Fieger law firm in this case?

A. I was.

Q. Is this the first time you have ever been hired by the Fieger law firm?

A. No.

Q. How many times previously have you been hired by them?

A. I don't know.

Q. Any idea?

A. No. I have been working with Mr. Fieger for many years, and he has called upon me from time to time, but I don't know how many times.

Q. Okay. I'm going to just try a little bit harder to be precise. More than 10?

A. Probably.

Q. More than 20?
A. Probably.
Q. More than 40?
A. Over the last 20 years, yes, sure.
Q. Let's keep going and see how far we get. More than 50?
A. Probably.
Q. Okay. More than 100?
A. Maybe.
Q. More than 150?
A. Could be.
Q. Okay. You just don't know?
A. That's right.
Q. But you are not ruling it out?
A. Well, I don't know. If you are asking me if something is possible, anything is possible.
Q. I think you probably have a pretty good recollection of your career over the last 20 years. I'm just asking is 150 a good ballpark?
A. It might be. I haven't counted, so I don't know. It might be.
Q. Okay. In this case how much were you paid by the Fieger law firm to do the evaluation and the report?

A. Usually when I get paid, there is a paid bill in the chart. I don't see one here. I haven't been paid yet, but I probably billed around $900 for the report -- for the evaluation, the record review and preparation of the report.

Q. Okay. Any other money that they would have paid you as part of this?

A. No. I have not billed anything yet.

Q. You have testified, from what you provided to us -- or not just testified, but have been involved in many cases over your career, correct?

A. Yes. I have been practicing for almost 40 years.

Q. Have you testified as an expert in cases?

A. I have.

Q. Is that primarily what you do when you testify?

A. In cases?

Q. Well, I mean do you do other things in the legal field in addition to --

A. Sure.

Q. Like what?

A. I give opinions on testamentary capacity, criminal responsibility, damages, standard of care. I consult as a forensic psychiatrist. I consult to municipalities. I do fitness for duty exams for employees. I'm the department psychiatrist for the Detroit Police Department. I have been for almost 30 years. So I see police officers who are involved in firearm incidents. I see firefighters. I do that for other jurisdictions who don't have their own psychiatrist but may have a need. I consult to insurance companies, disability management companies. I do all that.

Q. As relates to civil litigation, and I'm going to limit it to that, are you primarily hired by plaintiffs or defendants?

A. I would say when I'm retained, I would say it's about 50/50. I do work in a hospital. I have a specialty in brain injury rehabilitation. I have a specialty in chronic pain. I work in a general hospital and am on the teaching service that provides psychiatric care to medically ill patients or physically ill patients, and so I often am called on to treat people who are injured

in industrial accidents or motor vehicle accidents. I treat them and I'm often asked to give testimony in their cases, so I'm not really a plaintiff's witness. I'm a treating physician. I would exclude that in the calculations. My sense is when I'm retained it is about 50/50.

Q. Okay. I don't know if you are making a distinction between retained and actually testifying. Are you? I don't know.

A. Oh, no. Retained -- well, let me just say that often when I'm retained by the defense, those matters often don't proceed to deposition or they don't proceed to trial. When I'm retained by plaintiff, they seem to be more likely to proceed to trial. When an attorney hires me, it's just as likely to be a representative of a plaintiff as a defendant.

Q. The Fieger law firm can you calculate were you retained in a plaintiff's capacity or defendant's capacity in the Fieger cases?

A. It's my understanding that the Fieger firm mostly represents plaintiffs.

Q. So the answer would be, to your knowledge, all or most of your retaining by Fieger

would be plaintiff oriented?

A. Maybe. Probably. I don't know. I really haven't undertaken a survey or review.

Q. I'm not asking for a survey. I'm asking for your recollection and knowledge as we sit here today.

A. Yes, maybe.

Q. Okay. Doctor, I don't have any further questions. Thank you very much for your time.

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(The deposition was concluded at 7:10 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

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CERTIFICATE OF NOTARY

STATE OF MICHIGAN)

) SS

COUNTY OF OAKLAND)

I, Linda S. Wilson, certify that this deposition was taken before me on the date hereinbefore set forth; that the foregoing questions and answers were recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to, either party nor interested in the event of this cause.

LINDA S. WILSON, CSR-0973
Notary Public,
Oakland County, Michigan.

My Commission expires: 2/24/19.

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Linda S. Wilson

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My Commission expires: 2/24/19.